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ABSTRACT

This special project, manned by volunteers, aimed at seeking out and serving "homebound elderly" among whom 22 desired such intervention. College students, middle-aged and older adults were involved in conducting weekly visits. Although no special effort was made to recruit young volunteers for this project, it is suggested that such assignments can be made successfully. Most of 49 referrals were cited as homebound because of physical disabilities, and fewer than half lived alone. Assumptions about elderly homebound who live alone, are lonely, and who, therefore, should be sought out in a general way, are not warranted. Instead, agencies are encouraged to participate in organized surveys of their local communities in order to differentiate the various needs of older persons. The call to assist the elderly has widened the generation gap between young and old people. To help close this gap, the authors suggest interagency, interorganizational community models that are designed to direct teenage and college youth into helping roles that include home visiting, escort service and shopping for older adults. Social workers of various specialties can help fashion such cooperative models. (Author/SE)

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The Homebound Elderly: An Intergenerational Problem

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The Homebound Elderly: An Intergenerational Problem

Federally funded programs have been increasingly applied to help older people in their own homes because of illness, indigence or immobility. As for illness, public health agencies have initiated many new programs to enlist home health aides, nurses and homemakers to fill unmet medical needs within the elderly community, as distinguished from treatment in hospitals and closed institutions (Brody, 1973; Bechill, 1970). As for indigence, the Older American Act has increased the visibility of impoverished older people in the community, with its emphasis on arranging transportation, escort services and meals-on-wheels programs.

As for immobility, however, private organizations, church groups and social agencies frequently reach out, usually by means of volunteers, to the so-called "elderly homebound" people, whose various needs include nutrition, physical impairments or any combination of needs, including social needs and socialization. This mixed picture deserves closer attention, more study and possible research.

A sectarian agency brochure states that its "friendly home visitor program is the backbone of its comprehensive home care plan for elderly and chronically ill people"[1]. The primacy of a friendly home visitor volunteer program can only be confirmed, however, in relation to various needs and various kinds of home interventions. Being homebound, for example, is often loosely associated with being alone, with being cut off from social contact. As for our own concern

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[1] Your Friendly Visitor Handbook, Cardinal Ritter Institute, St. Louis, Missouri.

about those who live alone, more investigation is needed. In research designed to assess the adjustment of older adults in leisure-time program, the variable "living alone" was not in itself significantly related to program saliency (Goodman, 1974). Lowenthal (1970) cites Townsend, who distinguished between objective circumstances (isolation) and subjective states (loneliness)... "being alone is not necessarily correlated with loneliness". Since the phenomena of living alone and being homebound are difficult to research, the authors sought to review their experience in organizing a volunteer project to help "homebound" older adults to, hopefully, encourage additional fact-finding efforts concerning non-institutionalized older adults.

Some Questions About the Homebound Elderly

Three questions deserve consideration. A growing but generalized concern with the homebound elderly may be partialized as follows: 1) What are the conditions of "social isolation"? Is there a tendency to ascribe the characteristic of "being isolated" to all the homebound or so-called shut-ins? 2) To what degree are homebound persons functionally impaired, and can the impairments be noted and described? 3) The third question--if some older adults are immobilized socially, functionally or otherwise, what are the mental health implications, and might it be useful from a community health viewpoint to enroll young people to assist older people at home?

It has been pointed out that since a significant proportion of aged couples and individuals live at or below the poverty level, a coordinated system to include "at home" social and medical services is needed (Libow, 1974). But what do we mean by necessary "social" services? It has been pointed out by others that large cities such as New York have always attracted people who either seek... social contacts or who prefer to live aloof from others (Clark,

1971). Should public or private agencies seek to arrange home visiting as a general rule if a significant minority of urban elderly may be happy to "be left alone at home"? How can service agencies locate those households where environmental factors prevent normal socialization without the support of specially-funded case-finding such as in S. Bronx, N.Y. (Senior Advisory Service, 1969)? In brief, do we know what loneliness is and who the lonely people are? Do we tend to confuse loneliness with physical impairments that, situationally, impose restrictions on the mobility of older adults?

This brings us to the second consideration--the need for an accepted definition of functional impairment as distinguished from homeboundedness. It is acknowledged, at least among the helping professionals working in the field of aging, that we need more "parallel and integrated health services," provided in hospitals, nursing homes, in clinics, and extended into the homes of older adults. Inasmuch as at least 15% of all over 65 living at home are deemed to be functionally impaired (Bell, 1973), Bell offers a definition of functional impairment: "dependence on others... to cope with the normal demands of daily living, such as getting out of bed, bathing, dressing, preparing a meal, etc". Kahana points out that, based on research and on surveys, many persons living at home suffer from physical and mental problems which are as severe as those of the institutionalized aged (Kahanda, 1971). Since specialized health agencies are increasingly directing services into the open community, it behooves social workers to support friendly visiting as a specific health service. The socializing role that volunteer visitors can play is an important service to develop.

A third consideration flows from the above--namely, the intergenerational implications of age-segregated social isolation. Researchers have developed a

dominating concern that role-losses are not negligible and that socializing forces are not always available to various sections of our aging population (P.H.S., 1965). A study in Wisconsin, for example, revealed that in questioning respondents from early adolescence through old age "about whom they believed to be the important sources and transmitters of information to children and adolescents growing up in American today", not one of several hundreds of respondents mentioned grandparents (Looft, 1973). These investigators suggest that a program of life-span education might reintroduce the younger generation to the older generation..."to dispel distaste and fear...". Redeveloping "respect for the experience and wisdom of the aged, among the young, and helping the elderly to see the value of the ambitions and the complaints of the young", might well be a domestic policy program for this convention to explore. The Older American Act as amended promulgates the principle of active, voluntary support, including youth organizations at the high school or college level (Public Law 93-29, 93rd Congress, S. 50, May 3, 1973). The implications of arranging for younger-age persons to do friendly home visiting is therefore a special consideration. The material below reviews referral sources, some of the characteristics of the elderly referrals, response to the service and some ideas about shaping and developing this kind of volunteer service on an intergenerational basis.

Evolvement of the Special Project[2]

Social workers developed this special project by extending the organized efforts of telephone reassurance volunteers to include home visiting in order to examine the characteristics of "homebound" elderly in the same neighborhood, as well as to provide a service, after one older adult had been shown the feasibility of regularly visiting two homebound members of the agency for over a year, in addition to serving as captain of the telephone reassurance committee. The latter was made up of ten older adult women who made morning calls to an

[2] Social workers of the Senior Adult Dept., St. Louis Jewish Community Centers Assn.

average "load" of 20 members deemed to be sick or homebound. The idea of extending these volunteers' efforts (an accepted indigenous leader and followers) to include friendly home visiting, without special funding, would depend at the outset on finding mobile volunteers, because the older adult telephone committee was itself dependent on the agency's transportation. College students and volunteers of all ages were welcomed. At the same time, the staff had to promote and advertise the availability of a new home visiting service to families and friends.

The approximate 2-mile radius can be described as lower-middle class, mostly private homes, but including two congregate apartments designed for older adults, and a sprinkling of small apartment buildings.

The staff operationalized this project because a retired social worker volunteered two days a week in order to select referrals and home visitors, and to match them. Prior to the start of the volunteer coordinator's effort in October 1972, the Older Adult Department had organized four volunteers serving six clients; now, the project expanded until an average of 12 volunteers were serving 14 home clients. Informal training stressed the need to know about specialized supportive services, to interpret such information and to be a good listener; to refrain from administering medicine, and from doing housekeeping. Nearby shopping, going for a walk, playing records and similar activities were encouraged. Brief monthly reports were required. Some highlights of the supervisory relationship included: the case of a new volunteer who quit because her client was not living in dire poverty; handling the anxiety of an 84-year-old male volunteer whose two successive cases died. The coordinator recorded the ages of all referrals, sources of referral (whether the call came from reading about the service or from a son or daughter, from another older adult, etc), the major problems or complaints of the person being

referred, his household composition, the gripes or satisfactions of both clients and volunteers. With this information on hand, the results of 15 months of outreach are summed up below - a) the volunteers, and b) characteristics of the elderly homebound.

Results of the Project

a) The volunteers: description of volunteer home visitors.

During this 15-month effort, 21 volunteers were selected and assigned to one or two elderly persons. The volunteers, whose visitations were once a week, ranged in age from 22 to 83 years. Fourteen were females and 7 were males. Nine of them continued for a full year or longer, and four of them withdrew after three months because they were field work students.

The volunteers are grouped according to age as follows: 1) there were ten older adults (65 or older), 2) four students, and 3) seven middle-aged. The older adults were evenly divided by sex, suggesting that men can be recruited for service. Religious identification seemed to be an important motivation for the older adults, with the humanistic impulse verbalized frequently by the older men. A childless couple, for example, expressed the need for social approval for "doing good". One older woman was proud that her grown family placed her in high esteem for being a home visitor, and one older man spoke often about his family's pride in this involvement. All but one of the ten older adult volunteers were also active in two or more organizations, thereby acting out the contention that life styles extend beyond retirement. Our experience with these older adult volunteers suggests that older adults can be enrolled as home visitors and can serve as role models for their families and for the local community.

The student volunteers served as home visitors by assignment. Although their motivations differed, they were all further stimulated to enter the social work or public welfare field with a positive attitude to work with the elderly.

The seven middle-aged volunteers, including one man, were closely identified with their fraternal and/or service organizations, such as a synagogue group, a B'nai Brith lodge, etc. They keenly viewed this experience as an extension of their prior organizational commitments.

The middle-aged volunteers also expressed personal satisfaction, often quoting their children, who said they were proud or thrilled with their assignments as home visitors. Reasons for their withdrawal included one situation, where the volunteer's own mother became bedridden and another where the woman had to help her husband in his own work. The middle-aged volunteers exemplified a helper role to their families and to the local community in the same manner as did the older and younger volunteer visitors. From the standpoint of community mental health, however, the direct involvement of high school and college-age youths to enter into a humanizing relationship with older adults, on a volunteer basis, deserves more consideration by community agencies.

b) Characteristics of elderly homebound.

Forty percent of these referrals were males, less than half of the referrals accepted a friendly visitor, and the main problem presented by 49 referrals seemed to be physical rather than psychological. The case notes compiled by the coordinator do not suggest that feeling lonely or depressed was a predominating reason for referral - in only 12 of the 49 home situations (25%) did this appear to be the main reason (Table I). Only two of these 12 accepted a friendly home visitor, and only two of the 12 initiated the referral herself. Table I suggests that the reasons for referral were recent injuries or illnesses for the most part. It may be an unwarranted assumption that loneliness, not complicated by a physical impairment, is a general condition among urban, elderly persons who live at home. In many situations, older persons who live

alone may prefer a high level of privacy. Other conditions that stringently limit a person's mobility, such as visual problems, may elicit a greater response to having a visitor (Table I). At the very least, research into the disablements among older populations living in their own homes is suggested so that agencies might more efficiently assign priorities to their volunteer cadres.

(Table I about here)

Who are the community agents most concerned about older adults at home? Table II suggests that the Senior Center department itself, through its sick book, its staff and its older adult membership, provided the majority (32 out of 49) referrals to the coordinator. Word of mouth interest overshadowed the results of bulletins and printed announcements. The role of the volunteer coordinator in drawing attention to the needs of elderly people who might benefit from the intervention of a friendly visitor cannot be assessed, but agencies serving the elderly might be advised to establish such roles on a paid or volunteer basis. It is suggested also that encouraging elderly peer group interest can provide a stable base for case finding in the surrounding neighborhood.

(Table II about here)

The household composition of the referrals suggests that the characteristic of living alone was the case in only 21 of 49 referrals (Table III). Of these 21, only 9 accepted a home visitor, and only two of them referred themselves. These descriptive data further suggest that man and wife households may represent an important area for study, especially where physical impairments or illness limit the mobility of the spouse. There was also evidence of as much desire for friendly visiting among households that included [illegible] siblings, grown children and other relatives as there was among singles.

(Table III about here)

The characteristics of urban older adult households vary widely, of course. Even though the life styles of S. Bronx elderly apartment tenants strikingly differ from the people reffered to our agency in St. Louis, the common assumption that older people who "live alone" are necessarily needful deserves more

careful inspection within each local community.

Summary

A special project manned by volunteers aimed at finding and serving "homebound elderly" in the surrounding community of a group service-agency received 49 referrals, among whom 22 desired the intervention. College students, middle-aged and older adults were involved in conducting weekly visits. Although no special effort was made to recruit young volunteers for this project, it is suggested that such assignments can be made successfully. Most of 49 referrals were cited as homebound because of physical disabilities, and less than half lived alone. Assumptions about elderly homebound who live alone and who feel lonely, and who therefore should be sought out in a general way, are not warranted. Instead, agencies are encouraged to participate in organized surveys of their local communities in order to differentiate the various needs of older persons.

Recommendations

It is recognized that inadequate transportation, inadequate housing, low income, other objective factors contribute to social isolation. At the same time, being "homebound" is a condition that may be due to factors that require careful examination on a case-by-case basis. The recruitment of friendly visitors should be viewed as a distinctive aspect of preventive health work. The separate and distinctive roles of health aides, homemakers and meals-on-wheels volunteers in serving older adults who are less mobile or more socially isolated than younger people do not take the place of the humanizing role of the friendly home visitor. On the local level, categorical supportive services for the elderly are at best fragmentary, and friendly visitor programs designed to complement the services of specialized agencies are recommended.

The call to action to help the elderly has unfortunately widened the breach between young people and old people in America today. While it is true that experts point out that "American society... is not comfortable about the aged in its midst" because our older people live in greater relative poverty and are offered social services that are underdeveloped, (Blenkner, 1971) it is also true that the aging process is a continuum that younger persons fail to appreciate. As a result, growing numbers of young people are denied the opportunity to develop a perspective that includes aging as a process. The imminent problems of financial security and health security affect younger workers, as for example the definition of "older worker" as persons age 45 and up (Bulletin 1721, U.S. Dept. of Labor, 1971, p. 2). Public policy is now developing to transform Medicare into health insurance for all age groups, and other programs increasingly acknowledge that public policy has to meet citizens' needs regardless of chronological age. Efforts to engage young people in voluntary work with older adults can help them to appreciate aging as an all-encompassing process that includes themselves as citizen-actors who can empathize with the gradual changes of day-to-day existence.

From this point of view, associations of older adults such as AARP, the National Congress of Senior Citizens, and the like, cannot help to close the gap between our two largest population groups. The elderly groups are already age-segregated, special interest groups dedicated to the maintenance of their remaining rights and privileges. On the other hand, associations of young fraternal, social and business groups might better serve their own members by becoming engaged, as a result of professional leadership by the helping professions, in voluntary projects such as home visiting. Some of our family case work agencies are beginning to recruit younger volunteers, going into homes

of older adults as assigned and supervised by case workers. Youth-serving organizations in St. Louis have also initiated service projects for the elderly, but their efforts are usually aimed at visiting elderly persons living in nursing homes. Inter-agency, inter-organizational community models are recommended that are designed to direct teen-age and college youth into helping roles that include escort service, shopping and home visiting with and for older adults who live in the open community. School social workers, juvenile workers in protective agencies, group workers and the like can help fashion such cooperative models, models based on the perspective so aptly characterized by the cartoon hero who said "I have met the enemy and he is us!"

Table I Problems of 49 Homebound Referrals

Problem	Sex F	Sex M	Total Cases		Disposition Accepted	Disposition Refused
Visual						
Cataract operation, recent	2		2	6	2	
Limited vision		1	1		1	
Blind	1	2	3		2	1
Other Physicial Limitations						
Stroke	4	3	7		2	5
Heart Problem	1	1	2		1	1
Circulatory problem	3		3		3	
Severe Arthritis		1	1		1	
Diabetes	1		1			1
Bleeding ulcers		1	1		1	
Leg ulceration	1		1			1
Iatrogenic impairment		1	1			1
Leg fracture, recent	1		1			1
Leg amputation, recent		2	2		1	1
Minor female surgery, recent	1		1			1
Prostatectomy, recent		1	1			1
Parkinson's disease	2		2		1	1
"Infirm"	1		1		1	1
Auto accident, recent		1	1		1	
Multiple Sclerosis		2	2		1	1
Hip injury, recent	1		1		1	
Psychological						
Depressed widow	5		5	12	1	4
Depressed woman	3		3		1	2
Depressed man		2	2			2
"Confused mental state"	1		1			1
"Lonely"	1		1			1
Reason Unknown	1	1	2		1	1
Totals	30	19	49		22	27

Table II Sources of Referral

	Accepted Visitor	Refused Visitor	Total
1. Departmental Sick Book & Membership Drops	6	8	14
2. Active Older Adult Members	5	4	9
3. Older Adult Professional Staff	4	5	9
4. Agency Weekly and the Jewish Light	5	3	8
5. Physician	1	0	1
6. Clergymen	1	0	1
7. Wife		2	2
8. Son		1	1
9. Miscellaneous		4	4
Totals	22	27	49

Table III Household Composition

	Accepted Visitor		Refused Visitor		Total
	Male	Female	Male	Female	
Widow Alone		8		10	18
Man Alone	2		1		3
Total*					
With a sibling		1			1
With married child	2	1	1	1	5
With spouse	4	1	6	4	5
With housekeeper	1				1
In nursing home	1			1	2
With unmarried child		1		2	3
With mother			1		1
Total	10	12	9	18	49

*Only 42.8% lived alone. Of these (21 cases) only two voluntarily called in for a visitor, and in two other cases a grown son or daughter called in, i.e., the staff coordinator reached out to 17 of the 21 "live alone" contacts.

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